

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

8451

**1. PLACE OF DEATH**

County.....

Registration District No. 781

Township.....

Primary Registration District No. 1003

City St. Louis (No. Inventory to Hosp)

File No. ....

Registered No. 2117

St. .... Ward)

**2. FULL NAME**

James Augustine Wais James Sibley

(a) Residence No. 2332 Palmyra St. 22 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

male

**4. COLOR OR RACE**

Colo

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

married

**5A. IF MARRIED, WIDOWED, OR DIVORCED**

HUSBAND OF (OR) WIFE OF

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Feb. 7, 1895

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>34</u>	<u>-</u>	<u>3</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

**PARENTS**

**10. NAME OF FATHER** Samuel Sibley

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**  
 (STATE OR COUNTRY) Not Known

**12. MAIDEN NAME OF MOTHER** Lottie Wright

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**  
 (STATE OR COUNTRY) Mississippi

**14. INFORMANT** Florence Augustine  
 (Address) 3419 Hadkinson

**15. REGISTRAR** J. H. Harrison  
 FEB 15 1929

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 2-10-29 19

**17. I HEREBY CERTIFY, That I attended deceased from**....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 5 P.....m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

167  
gun shot wound of head  
 (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)** Suicide  
 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Wm V. Dewar, M.D.  
Coroner

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Music  
**DATE OF BURIAL** Feb. 17 1929

**20. UNDERTAKER** J. H. Harrison  
**ADDRESS** 2906 Lawton

N. B.—every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

23  
1  
31  
2

